

**NOTIFICATION OF MEDICAID/HCBS/WORKING HEALTHY SERVICES
CHANGES / UPDATES**

ES-3161
Rev. 7-07

TO: _____ **FROM:** _____
ADDRESS: _____ **ADDRESS:** _____

I. CONSUMER INFORMATION:

Name: _____
Case Number (If Known): _____ Medicaid ID #: _____
Address Change: _____ Date: _____
Responsible Person or Alternate Contact Change: _____ Date: _____

II. SRS MEDICAID INFORMATION CHANGES: (to be completed by EES Specialist or Social Worker)

<input type="checkbox"/>	Review Complete:	<input type="checkbox"/>	Approved / Denied	<input type="checkbox"/>	Working Healthy/WORK - Temporary Unemployment Plan Needed.
	Eff Date:		Next Review:		Date Last Employed
<input type="checkbox"/>	HCBS Obligation Change:	\$	Eff:		Reason for Unemployment
		\$	Eff:		
<input type="checkbox"/>	Medicaid Case Close Eff:		Reason:		
<input type="checkbox"/>	HCBS Client Employed (possible Working Healthy/WORK eligible):				
<input type="checkbox"/>	Other:				
Comments:					

III. HCBS SERVICE CHANGES: (to be completed by Case Manager/IL Counselor/WORK Manager)

<input type="checkbox"/>	HCBS/WORK Services Review: Approved/Denied	Effective Date:	
<input type="checkbox"/>	Level of Care Waiver Change To:	Effective Date:	
<input type="checkbox"/>	Monthly Cost of Services Change To: \$	Effective Date:	
<input type="checkbox"/>	HCBS/WORK Services Terminated -Effective Date:	Reason:	
<input type="checkbox"/>	Medical Bills for Obligation (Bills Attached)		
<input type="checkbox"/>	NF Entrance: Date Entered:	Facility:	Anticipated Length of Stay
<input type="checkbox"/>	Check one: <input type="checkbox"/> HCBS-Covered Respite	<input type="checkbox"/> Temporary Care	<input type="checkbox"/> Permanent/Undetermined
<input type="checkbox"/>	Other:		
Comments:			

IV. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)

Temporary Unemployment Plan Info:	<input type="checkbox"/>	Client Failed to Comply, Reason	<input type="checkbox"/>	Plan Developed
Premium Repayment:	<input type="checkbox"/>	Agreement Signed, Date Received		
Other:				
Comments:				

EES SPECIALIST/SOCIAL WORKER SIGNATURE

DATE

☐ YES ☐ NO
ATTACHMENTS:

CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE DATE

